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UNITED NATIONS POPULATION FUND
PROPOSED PROJECTS AND PROGRAMMES

Recommendation by the Executive Director
Assistance to the Government of Uganda

Proposed UNFPA assistance:	$29 million, $16 million from regular resources and $13 million through co-financing modalities and/or other, including regular, resources
Programme period:	5 years (2001-2005)
Cycle of assistance:	Fifth
Category per decision 2000/19:	A

Proposed assistance by core programme areas (in millions of $):

	Regular resources	Other	Total
Reproductive health	10.7	10.6	21.3
Population and development strategies	3.0	2.4	5.4
Advocacy	1.8	-	1.8
Programme coordination and assistance	0.5	-	0.5
Total	16.0	13.0	29.0

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UGANDA

INDICATORS RELATED TO ICPD & ICPD+5 GOALS*

		Thresholds*
Births with skilled attendants (%)[1]	38	≥60
Contraceptive prevalence rate (%)[2]	15	≥55
Proportion of population aged 15-24 living with HIV/AIDS (%)[3]	5.83	≤10
Adolescent fertility rate (per 1,000 women aged 15-19)[4]	180.3	≤65
Infant mortality rate (per 1,000 live births)[5]	107	≤50
Maternal mortality ratio (per 100,000 live births)[6]	510	≤100
Adult female literacy rate (%)[7]	50	≥50
Secondary net enrolment ratio (%)[8]	--	≥100

*AS CONTAINED IN DOCUMENT DP/FPA/2000/14 AND APPROVED BY THE EXECUTIVE BOARD IN DECISION 2000/19

[1] Electronic database, World Health Organization, December, 1999.
[2] United Nations Population Division, *Levels and Trends of Contraceptive Use as Assessed in 1998* (1999).
[3] UNAIDS. *Report on the Global HIV/AIDS Epidemic*, June 2000.
[4] United Nations Population Division, *World Population Monitoring, 2000: Population, gender and development* (forthcoming).
[5] United Nations Population Division, *World Population Prospects: The 1998 Revision*.
[6] The World Bank, *World Development Indicators, 2000*.
[7] UNESCO, *Education for All: Status and Trends* series (1997, 1998, 1999 editions).
[8] UNIFEM, *Targets and Indicators: Selections from Progress of the World's Women (2000)*, based on 1999 data from UNESCO.

Two dashes (--) indicate that data are not available.

Demographic Facts

Population (000) in 2000	21,778	Annual population growth rate (%)	3.21
Population in year 2015 (000)	34,475	Total fertility rate (/woman)	6.74
Sex ratio (/100 females)	99.2	Life expectancy at birth (years)	
Age distribution (%)		Males	43.8
Ages 0-14	50.1	Females	45.8
Youth (15-24)	20.3	Both sexes	44.8
Ages 60+	3.1	GNP per capita (U.S. dollars, 1998)	310

Sources: Data are from the Population Division, Department of Economic and Social Affairs of the United Nations, *World Population Prospects: The 1998 Revision*; GNP per capita is for the year 1998 from the UNDP, *Human Development Report 2000*, based on World Bank data (World Bank Atlas method).

N.B. The data in this fact sheet may vary from the data presented in the text of the document.

1. The United Nations Population Fund (UNFPA) proposes to support a population programme over a five-year period starting in January 2001 to assist the Government of Uganda in achieving its population and development goals. UNFPA proposes to fund the programme in the amount of $29 million, of which $16 million would be programmed from UNFPA regular resources to the extent that such resources are available. UNFPA would seek to provide the balance of $13 million from co-financing modalities and/or other, including regular, resources to the extent possible, consistent with Executive Board decision 2000/19 on the allocation of UNFPA resources. This would be the Fund's fifth programme of assistance to the country. Uganda is a "Category A" country under the Fund's resource allocation criteria.

2. The proposed programme was based on the outcome of workshops held with participants from the Government, non-governmental organizations (NGOs) and key United Nations partner agencies. The UNFPA Country Technical Services Team (CST) based in Addis Ababa, Ethiopia, provided technical guidance in the process. It takes into account the national policies, priorities and strategies expressed in the Uganda Vision 2025 as well as in the Poverty Eradication Action Plan (PEAP). The programme is based on the UNFPA Country Population Assessment (CPA) exercise, which was conducted by national consultants in collaboration with the Government's Population Secretariat and a wide range of stakeholders. Findings of the CPA were used in drafting the Common Country Assessment (CCA). Consultations during the CCA process ensured complementarity among the programmes of the United Nations partner agencies. Development of the United Nations Development Assistance Framework (UNDAF) is under way. UNDP, UNICEF and UNFPA programme cycles will be harmonized beginning in 2001.

3. The PEAP identifies four priority areas: creating a framework for economic growth and transformation; ensuring good governance and security; increasing the ability of the poor to raise their incomes; and enhancing the quality of life of the poor. UNFPA would assist the Government in attaining these goals in the areas of reproductive health and population and development. The goal of the Fund's proposed programme would be to contribute to a better quality of life for the Ugandan people through improved reproductive health, sustainable population growth and development, and enhanced gender equity and equality and women's empowerment. UNFPA support would be channeled through three subprogrammes: reproductive health, including family planning and sexual health; population and development strategies; and advocacy.

4. The proposed programme was developed within the framework of a human rights approach. All activities under the proposed programme, as in all UNFPA-assisted activities, would be undertaken in accordance with the principles and objectives of the Programme of Action of the International Conference on Population and Development (ICPD), which was endorsed by the General Assembly through its resolution 49/128.

Background

5. The demographic figures available for Uganda are primarily based on the 1991 national population and housing census and the 1995 demographic and health survey (DHS). The current estimated population of 22 million people is projected to reach 25 million by 2005. Life expectancy at birth was 48.1 years in 1995 but has fallen because of the ravages of the AIDS pandemic. The total fertility rate was estimated at 6.9. The maternal mortality ratio was estimated at 506 per 100,000 while infant mortality was 95 per 1,000 in 1995. In 1995, it was also estimated that by age 19, 71 per cent of girls had begun childbearing. Trained health workers attend about 38 per cent of deliveries.

6. Adult literacy in Uganda is estimated at 62 per cent, with adult male literacy estimated at 73 per cent and adult female literacy at 50 per cent. With the introduction of universal primary education in 1997, primary school enrolment had increased from 2.6 million in 1995 to 6.5 million by 1999 with a net enrolment ratio of 85 per cent and a participation rate of 53 per cent for males and 47 per cent for females.

7. Although awareness of family planning is nearly universal (93 per cent), use of contraception remains low. The contraceptive prevalence rate was estimated at 15 per cent for all methods and 8 per cent for modern methods. About 33 per cent of all births are not planned, and 8 per cent are unwanted. According to the 1995 DHS, 30 per cent of currently married women have an unmet need for family planning. The unmet need among adolescents is even higher – 55-85 per cent, according to a recent study. Contraceptive stock-outs at the district level are frequent. Many health service providers lack adequate knowledge and skills in providing quality services as well as positive attitudes in dealing with clients. There is a high incidence of unsafe abortion, especially among adolescents. It is estimated that as many as 25-35 per cent of maternal deaths occur as a result of abortion-related complications. Generally, men's sexual and reproductive health needs are not adequately addressed.

8. Uganda's successful efforts to reduce HIV prevalence levels have been characterized by a multisectoral approach involving a wide range of stakeholders backed by open political commitment at the highest level of the Government. As a result, according to UNAIDS and WHO, HIV prevalence among antenatal clinic attendees in Kampala was 31 per cent in 1990 and 14 per cent in 1998. A decline, although less dramatic, was also observed outside urban areas.

9. The Government of Uganda is party to the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and has established mechanisms for empowering women. However, there remains a critical need to enhance their social status and improve their

reproductive health. Sociocultural practices such as bride-wealth, early marriages, widow inheritance, female genital cutting (FGC) and wife sharing persist. Research findings indicate an increase in gender violence, including wife battering and rape. These same findings show that in several districts up to 20 per cent of adolescent girls have their first sexual experiences through forced sex or rape.

10. Decentralization has been implemented in all district and lower level councils. The Government has embraced a sector-wide approach (SWAp) for the health sector and agreed with stakeholders, including donors, on national development objectives and strategies for the health sector. The Governments of Denmark, Norway, Sweden and the United Kingdom will provide direct budget support for the health sector SWAp. The proposed UNFPA programme reflects national priorities reconfirmed through the SWAp. While the SWAp is still at a relatively early stage of implementation, UNFPA will follow developments and continue to advocate for inclusion of reproductive health, reproductive rights, and gender equity and equality in health-sector initiatives.

Previous UNFPA assistance

11. UNFPA began providing support to the Government of Uganda on a project-by project basis in 1972 and initiated the first country programme in 1985. The fourth country programme (1997-2000) was budgeted at $24 million, of which $16 million was to come from UNFPA regular resources and the rest from multi-bilateral sources. Reprogramming of regular resources from the area of population and development strategies to the areas of reproductive health and programme coordination and assistance were approved at the mid-term review. Under co-financing modalities, UNFPA received support from the Government of Norway. The total expenditure for the fourth country programme is estimated to be $15.3 million from regular resources and $4.4 million from multi-bilateral funds.

12. The overall objectives of the UNFPA programme were: (a) to update and implement the National Population Policy; (b) to assist the Government in the formulation of a national reproductive health strategy in the context of the ICPD; (c) to extend quality integrated reproductive health and family planning services from 783 to all 1,044 health centres in the 26 programme districts; (d) to contribute to the reduction of adolescent early pregnancies by 40 per cent in 20 districts; (e) to contribute to the reduction of maternal mortality by 30 per cent in 13 districts; (f) to advocate for and bring about positive social change vis-à-vis family formation patterns, reproductive health and rights, and gender equity and equality; and (g) to contribute to building the human resource and institutional capacity of the Government and NGO partners. These objectives were effectively addressed through the strategy of piloting innovative interventions with the broad participation of stakeholders. Some of these innovative approaches

have had a catalytic impact among other donors as well. However, some planned activities were not undertaken due to resource constraints. The lack of updated data has made it difficult to measure concrete programme achievements.

13. In the area of reproductive health, UNFPA supported extension of quality integrated reproductive health services in 30 districts. A wider range of reproductive health services was made available at the community level, and the capacity of service delivery points was strengthened through training, provision of equipment, and an enhanced health management information system. The National Health Policy and the Health Sector Strategic Plan are in place, taking into account the ICPD Programme of Action. The family planning clinical skills curriculum was revised and upgraded to reflect a comprehensive reproductive health approach. National and district reproductive health IEC working groups became operational, and a multimedia campaign on male participation and responsibilities in reproductive health was launched.

14. An innovative project to eliminate FGC in Kapchorwa district (REACH) has succeeded in creating an enabling environment to openly discuss FGC. There has been increased knowledge and positive change in perceptions regarding a range of issues on FGC. As a result, 68 per cent of the Sabiny elders replaced FGC with gift giving. A pilot project to address emergency obstetric care through a referral system (RESCUER) increased availability, accessibility and utilization of emergency obstetric care in eight districts, which resulted in the reduction of maternal mortality in some districts. Achievements could have been greater if the quality of services at the referral points was better. Promotion of adolescent reproductive health has gained acceptance among decision makers, health workers, teachers and parents in 13 districts under the PEARL project. Support was provided to 11 national NGOs that furnish reproductive health services and/or information so that their programmes could be made available to difficult-to-reach populations, such as Muslim communities. Despite such efforts, the delivery of reproductive health services remains uneven. The community-based distribution (CBD) of contraceptives needs closer review in view of the inadequate number of agents, lack of motivation and absence of refresher training. Adolescents continue to find access to public health facilities difficult, and the quality of programmes offered to adolescents at community centres requires further review. The impact of peer counselors should be examined to address problems relating to high dropout rates and inadequate training.

15. In the area of population and development strategies, the National Population Policy has been revised although further revision of indicators with new data is required. District Planning Units in all 45 districts have been strengthened. Sub-counties have set up development and planning committees, and district population profiles have been prepared. A master plan for the

2002 census was developed and printed, and 14 districts had been mapped by June 2000. Over the four years of the programme, 360 graduates were trained through a demographic training programme at Makerere University. As for advocacy, support for parliamentarians was a key strategy, and many national political leaders have strengthened their capacity to articulate population, gender and reproductive health concerns. A population advocacy and IEC strategy was formulated.

16. One of the lessons of the previous programme was the need to have relevant and timely data, disaggregated by age and sex, that can serve as baseline and process indicators. Another lesson is that an effective advocacy strategy needs to involve a broad range of stakeholders. Promoting positive behavioural changes requires a more comprehensive IEC strategy. As for geographical coverage, the past programme demonstrated that when funding is limited programmes need to concentrate on fewer districts if their results are not to be dissipated.

Other external assistance

17. The World Bank and the International Monetary Fund (IMF) are spearheading the Highly Indebted Poor Countries (HIPC) initiative for Uganda, the proceeds of which are earmarked to support poverty reduction, especially in the areas of education, primary health care, HIV/AIDS prevention and infrastructure development. The World Bank has provided funds for renovation of health facilities, as well as programmes to combat sexually transmitted infections (STIs) and HIV/AIDS, including the provision of condoms. WHO provides technical assistance in the area of reproductive health, while UNICEF supports such reproductive health activities as promoting safe motherhood and prevention of STDs and HIV/AIDS among young people. UNICEF currently provides support for adolescent reproductive health in five districts and under its new programme will support adolescent reproductive health and HIV/AIDS prevention in 24 districts in the amount of $7 million.

18. The European Union's adolescent reproductive health programme is investing $1.4 million in 8 districts. The United States Agency for International Development (USAID) completed a $44 million project designed to improve reproductive health services in ten districts and will implement the next phase (2000-2002) with a $16 million budget. USAID also supports a social marketing programme.

19. The Rockefeller Foundation is providing funding for a data bank on adolescent reproductive health. With an additional $15 million from the Bill and Melinda Gates Foundation, UNFPA, together with two international NGOs, PATH and Pathfinder International, will be able to expand the ongoing adolescent reproductive health and HIV/AIDS prevention programmes, including the PEARL project, to all 45 districts in the country through the African

Youth Alliance (AYA) programme. In terms of geographical coverage, all donors complement inputs by others, even when working in the same districts, by choosing different sub-counties for implementation.

Proposed programme

20. The overall goal of the proposed programme is noted in paragraph 3 above. The proposed programme would place particular emphasis on capacity building, systematic monitoring and evaluation, and on effective participation, collaboration and coordination of a wide range of partners. Given likely budgetary limitations, the reproductive health subprogramme will focus on limited geographic coverage (15-20 districts out of 45) targeting districts already participating in the PEARL and RESCUER projects. The exception will be activities undertaken with the AYA, which will have a national coverage. The advocacy and population and development strategies subprogrammes will also be national in scope. In case of extraordinary circumstances, emergency assistance may be required in some areas. Using a small reserve of funds, such support would be provided for under the reproductive health subprogramme as the need arises.

21. Reproductive health subprogramme. Key issues to be addressed under the reproductive health subprogramme include under-utilization of reproductive health services, high rates of unwanted and unplanned pregnancies, and inadequate capacity to meet needs in reproductive health, including family planning, emergency obstetric care and referral, management of complications of abortion, adolescent reproductive health, and HIV/AIDS prevention. The purpose of the reproductive health subprogramme would be to contribute to increased utilization of quality reproductive health services as well as information and knowledge leading to adoption of safer and responsible sexual and reproductive health practices.

22. The first output would be increased access by women and men to quality reproductive health services through: (a) strengthened reproductive health services, including family planning, pre- and post-natal care, delivery, and STI management; (b) a strengthened and expanded referral system for emergency obstetric care; and (c) a strengthened community-based system of reproductive health workers. To achieve these results, the programme would work to increase provision of maternal and family planning services as well as to further strengthen the referral system for emergency obstetric care and for managing complications from abortions.

23. The second output would be strengthened technical, managerial and institutional capacities to provide quality reproductive health services. The focus would be on: (a) strengthening the technical and managerial capacity of individual health service delivery points;

(b) strengthening institutional capacity in coordination, planning, supervision, monitoring and evaluation of programmes at national, district and health sub-district levels; and (c) improving contraceptive logistics, management and distribution. This output would aim at equipping at least 70 per cent of health personnel with the above-listed skills and also at increasing utilization of monitoring and evaluation instruments for reproductive health programmes, improving management of contraceptive supplies and ensuring the availability of reproductive health data disaggregated by sex and age at all levels.

24. The third output would be increased knowledge of, skills in, and enhanced support for reproductive health, male involvement, and changes in attitudes concerning harmful practices among health service providers, law enforcement officers, men, and women. As part of the overall strategy to promote reproductive health, special attention would be given to initiatives designed to create a favorable environment for the elimination of harmful practices. Appropriate IEC strategies would promote the responsibility of men in fostering reproductive health.

25. The fourth output would be strengthened technical capacity among relevant government institutions and civil society organizations, including NGOs, to deliver appropriate reproductive health messages and services consistent with the ICPD Programme of Action. This output would focus on coordinated and harmonized production and dissemination of reproductive health messages. Efforts would be made to ensure that participating civil society entities, including cultural and religious institutions and community-based organizations, provide complementary support in target districts. Service providers, community workers and law enforcement officers will be trained on how to identify and counsel persons suffering from gender-based violence.

26. The fifth output would be to increase the availability of reproductive health services and information for adolescents with special emphasis on HIV/AIDS prevention. This will mostly be undertaken under the AYA programme, a multi-bilateral component with support from the Bill and Melinda Gates Foundation. The AYA programme will expand the adolescent reproductive health programme, which is currently being implemented by a number of local as well as international actors, including the UNFPA-funded PEARL project, to all 45 districts. Pathfinder International and PATH will have responsibility for training and expanding of adolescent reproductive health services and for communication in support of behavioural change, respectively, in close collaboration with UNFPA. UNFPA will be responsible for policy, advocacy, coordination and procurement. Of the $15 million granted by the Bill and Melinda Gates Foundation, UNFPA receives $7.1 million. In addition, UNFPA will allocate $1 million from regular resources for direct support to PEARL. Additional support will be sought through multi-bilateral channels, and the Government of Norway has expressed interest. UNFPA aims to generate a total of $2 million in multi-bilateral assistance for this endeavour, which would enable the programme to extend full coverage in the existing 13 PEARL districts.

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27. Reproductive health commodity security. For the period 2001-2002, the Ministry of Health has forecast that the total public sector demand for contraceptives will total $6.7 million. Key assistance for contraceptive management and procurement comes from USAID, the Department for International Development (DFID) of the United Kingdom and the World Bank. The Ministry of Health has budgeted an amount equivalent to $1 million for contraceptives for 2000/2001, which is likely to be covered by a contribution from DFID. USAID supports contraceptive supplies in its programme districts, and the World Bank may continue supporting condom procurement. In light of the support provided by other donors to ensure contraceptive security, UNFPA would limit its assistance to continued support for logistics management.

28. Population and development strategies subprogramme. The key issues in the area of population and development strategies are: (a) scarcity of data and analyses for designing, implementing and evaluating population and reproductive health policies and programmes; (b) insufficient integration of population and reproductive health concerns in development policies, plans and programmes; (c) limited capacity to collect, analyse and utilize information on population, reproductive health and gender issues; and (d) inadequate awareness of the ways in which population and development issues interact. The purpose of the proposed subprogramme would be to contribute to enhanced integration and reflection of population issues in policy formulation, planning and implementation of programmes at all levels.

29. The first output would be enhanced technical and institutional capacity at national, district and sub-county levels with respect to: (a) collecting, analysing and disseminating population and reproductive health information and related data; and (b) mainstreaming gender issues in policy, planning and programme implementation. Makerere University and the Bureau of Statistics will undertake the training of relevant district, sub-county and NGO staff. Gender training, particularly for staff at district and lower levels, will also be undertaken. Training to keep up with software developments in management information systems (MIS) will be carried out, and staff at the district level will be trained in database development and management.

30. The second output would be improved availability and accessibility of population data and research findings. Emphasis would be placed on assisting the Government to ensure that the 2002 census is designed and conducted effectively. Efforts would be made to promote a dialogue between the Bureau of Statistics and the prospective users of the information as well as to facilitate early and easy access to the full range of results; increase knowledge and usage of the results of the 2000 DHS; and enable districts to prepare detailed, user-friendly, gender-disaggregated population data as well as projections.

31. The third output would be increased knowledge and understanding among community leaders and households about population and development interrelationships and their policy implications. Key stakeholders at national and community levels will be sensitized about the 2002 census and will be involved in its planning and implementation as well as in the utilization of results. A multimedia and multisectoral information campaign before the census would be supported. This would be facilitated by the broad involvement of civil society organizations.

32. Advocacy subprogramme. Advocacy interventions will be designed to help the people of Uganda adopt policies, laws and programmes that respond appropriately to challenges in the area of reproductive health, adolescent reproductive health, HIV/AIDS, harmful practices and gender issues. They will also aim to increase understanding of and support for population and development issues, including gender and reproductive rights, adolescent reproductive health needs, and HIV/AIDS, by decision makers at local levels and to increase resource allocation for population and reproductive health activities. The advocacy strategy would call for the participation of a large variety of community leaders and organizations, such as decision makers in sectoral ministries, parliamentarians, media partners, women's and youth groups, traditional and religious leaders and civil society organizations.

33. The first output would be strengthened capacity of planning and coordinating institutions for resource mobilization to support population and development, reproductive health and gender programmes at national, district and sub-county levels. Support would be provided to the Population Secretariat and District Planning Units to enable them to mobilize local resources to complement the efforts of development partners in the area of population.

34. The second output would be strengthened institutional and technical capacity for advocacy of national, district, and cultural and religious institutions to address issues concerning population and development, reproductive health and rights, adolescent reproductive health, HIV/AIDS, harmful practices and gender. The Population Secretariat and District Planning Units and key advocacy coalition partners will be supported as part of this output.

35. The third output would be better understanding among policy and decision makers, religious, community and cultural leaders of the interrelationships between sociocultural, economic and political factors and population and development, reproductive health and rights, and gender. Effective IEC strategies would be built into the advocacy activities of the coalitions and institutions involved.

Programme implementation, coordination, monitoring and evaluation

36. The proposed programme will continue to promote national execution of programme

activities. While the Government would execute most component projects, arrangements would be made for some projects to be executed by NGOs. The coordination role of the programme would lie with the Ministry of Finance, Planning and Economic Development through the Population Secretariat. At the national and district levels, the Population Secretariat and District Planning Units would coordinate and monitor the implementation of the population and development strategies and advocacy subprogrammes. The Ministry of Health would coordinate implementation of the reproductive health subprogramme. Efforts will be made to establish a maternal health theme group to ensure a coordinated effort in programme planning and implementation in that area.

37. Programme implementation would be monitored and evaluated in accordance with established UNFPA guidelines and procedures. A comprehensive monitoring and evaluation framework is being prepared. In addition to annual subprogramme reviews, a mid-term review would be held in the second half of 2003 and an end-of-programme evaluation would be undertaken in 2005. Since official data used for indicators are outdated, baseline research and surveys are currently being undertaken. The results of the DHS and the 2002 census, both supported by UNFPA, will also be utilized to revise the logical framework indicators.

38. The UNFPA country office is composed of a Representative, a Deputy Representative, two Assistant Representatives and one Junior Professional Officer plus seven support staff. National Professional Project Personnel would be hired to support the substantive management and monitoring of subprogrammes. Technical and support personnel necessary for the AYA programme will be recruited under the project. The CST based in Addis Ababa would provide technical backstopping for the programme. Under the proposed programme, the amount of $500,000 would be used for programme coordination and assistance.

Recommendation

39. The Executive Director recommends that the Executive Board approve the programme of assistance to the Government of Uganda, as presented above, in the amount of $29 million for the period 2001-2005, $16 million of which would be programmed from UNFPA regular resources to the extent such resources are available, and the balance of $13 million would be sought through co-financing modalities and/or other, including regular, resources to the extent possible, consistent with Executive Board decision 2000/19 on the allocation of UNFPA resources.

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